

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0023218</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Friendship Village-Schaumburg</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/00</u> to <u>03/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>350 W. Schaumburg Road</u> <u>Schaumburg</u> <u>60194</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(847) 843-4259</u> Fax # <u>(847) 884-5718</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Date) _____	
IDPA ID Number: <u>36-2815382001</u>		(Print Name and Title) <u>Mr. Steven Lavenda, C.P.A.</u>	
Date of Initial License for Current Owners: <u>01/01/77</u>		(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Road, Suite 300, Deerfield, IL 60015</u>	
Type of Ownership:		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Friendship Village-Schaumburg# 0023218 Report Period Beginning: 04/01/00 Ending: 03/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>250</u>	Skilled (SNF)	<u>250</u>	<u>91,250</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>250</u>	TOTALS	<u>250</u>	<u>91,250</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,892</u>	<u>45,514</u>	<u>5,589</u>	<u>57,995</u>	8
9	SNF/PED					9
10	ICF	<u>4,274</u>	<u>22,369</u>	<u>38</u>	<u>26,681</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,166</u>	<u>67,883</u>	<u>5,627</u>	<u>84,676</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.80%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Home Health, Clinic

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 29 and days of care provided 5,028Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 3/31/01 Fiscal Year: 3/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Friendship Village-Schaumburg # 0023218 Report Period Beginning: 04/01/00 Ending: 03/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,053,866	211,057	2,004	1,266,927		1,266,927	(576,999)	689,928			1
2	Food Purchase		1,430,956		1,430,956		1,430,956	(652,294)	778,662			2
3	Housekeeping	648,026	71,434	5,498	724,958		724,958	(624,647)	100,311			3
4	Laundry	174,629	40,746	29,994	245,369		245,369	(25,437)	219,932			4
5	Heat and Other Utilities			806,148	806,148		806,148	(694,603)	111,545			5
6	Maintenance	459,909	75,225	692,997	1,228,131		1,228,131	(1,094,899)	133,232			6
7	Other (specify):*			377,376	377,376		377,376	(325,159)	52,217			7
8	TOTAL General Services	2,336,430	1,829,418	1,914,017	6,079,865		6,079,865	(3,994,038)	2,085,827			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	4,946,742	279,918	357,193	5,583,853		5,583,853	(409)	5,583,444			10
10a	Therapy			42,073	42,073		42,073		42,073			10a
11	Activities	332,887	1,510		334,397		334,397		334,397			11
12	Social Services	138,112			138,112		138,112		138,112			12
13	Nurse Aide Training											13
14	Program Transportation			122,975	122,975		122,975		122,975			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,417,741	281,428	536,641	6,235,810		6,235,810	(409)	6,235,401			16
	C. General Administration											
17	Administrative	738,887			738,887		738,887	(346,548)	392,339			17
18	Directors Fees			79,080	79,080		79,080	(68,133)	10,947			18
19	Professional Services			289,324	289,324		289,324	(257,506)	31,818			19
20	Dues, Fees, Subscriptions & Promotions			165,207	165,207		165,207	(5,928)	159,279			20
21	Clerical & General Office Expenses	926,421	339,472	416,562	1,682,455		1,682,455	(905,731)	776,724			21
22	Employee Benefits & Payroll Taxes			2,336,087	2,336,087		2,336,087	(1,268,092)	1,067,995			22
23	Inservice Training & Education											23
24	Travel and Seminar			27,543	27,543		27,543	(13,826)	13,717			24
25	Other Admin. Staff Transportation			4,067	4,067		4,067	(2,257)	1,810			25
26	Insurance-Prop.Liab.Malpractice			211,487	211,487		211,487	(190,790)	20,697			26
27	Other (specify):*											27
28	TOTAL General Administration	1,665,308	339,472	3,529,357	5,534,137		5,534,137	(3,058,811)	2,475,326			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,419,479	2,450,318	5,980,015	17,849,812		17,849,812	(7,053,258)	10,796,554			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Friendship Village-Schaumburg #0023218 Report Period Beginning: 04/01/00 Ending: 03/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,804,987	2,804,987		2,804,987	(2,353,411)	451,576			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,202,935	1,202,935		1,202,935	(1,036,488)	166,447			32
33	Real Estate Taxes			441,159	441,159		441,159	(380,117)	61,042			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			4,449,081	4,449,081		4,449,081	(3,770,016)	679,065			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	404,143	650,207	36,049	1,090,399		1,090,399		1,090,399			39
40	Barber and Beauty Shops			946	946		946		946			40
41	Coffee and Gift Shops	22,147		42,120	64,267		64,267		64,267			41
42	Provider Participation Fee			136,875	136,875		136,875		136,875			42
43	Other (specify):*			2,318,300	2,318,300		2,318,300	(2,318,300)				43
44	TOTAL Special Cost Centers	426,290	650,207	2,534,290	3,610,787		3,610,787	(2,318,300)	1,292,487			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,845,769	3,100,525	12,963,386	25,909,680		25,909,680	(13,141,574)	12,768,106			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Friendship Village-Schaumburg# 0023218Report Period Beginning: 04/01/00Ending: 03/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(591)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,393	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,802		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,802		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Friendship Village-Schaumburg

ID# 0023218

Report Period Beginning: 04/01/00

Ending: 03/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Non-Allowable Expenses:	\$		1
2	Special Events - Corporate	(4,382)	43	2
3	Bank & Investment Fees	(146,138)	43	3
4	Sales/Marketing	(346,691)	43	4
5	Waitstaff	(430,372)	43	5
6	Community Coordinator	(52,867)	43	6
7	Chapel Expense - IL/AL	(820)	43	7
8	Assisted Living	(20,906)	43	8
9	Wages - Assisted Living, Sales/Maketing	(791,549)	43	9
10	Programs - IL/AL	(189,396)	43	10
11	Fund Raising	(43,343)	43	11
12	Wages - Fund Raising	(86,425)	43	12
13	Bad Debts	(202,433)	43	13
14	Legal Fees (Retainer)	(4,000)	19	14
15	Legal Fees (Out of Period)	(3,063)	19	15
16	Legal Fees (Late Bill Accrual)	(2,100)	19	16
17	Out of State Seminars	(13,286)	24	17
18	Out of State Seminars miscoded to Travel Acct.	(2,257)	25	18
19	Damage Claims Paid	(8,566)	26	19
20	Jury Duty Income	(409)	10	20
21	Village Events	(2,259)	43	21
22	Chapel Honorarium	(250)	43	22
23	Non-HCC Dietary	(576,999)	1	23
24	Non-HCC Food	(651,703)	2	24
25	Non-HCC Housekeeping	(624,647)	3	25
26	Non-HCC Laundry	(25,437)	4	26
27	Non-HCC Heat & Utilities	(694,603)	5	27
28	Non-HCC Maintenance	(1,058,198)	6	28
29	Non-HCC Disposal & Security	(325,159)	7	29
30	Non-HCC Administrative	(346,548)	17	30
31	Non-HCC Director's Fees	-68133	18	31
32	Non-HCC Professional Services	-248343	19	32
33	Non-HCC Clerical & General	-905616	21	33
34	Non-HCC Employee Benefits	-1268092	22	34
35	Non-HCC Insurance	-182224	26	35
36	Non-HCC Depreciation	-2355804	30	36
37	Non-HCC Interest	-1036488	32	37
38	Non-HCC Real Estate Tax	-380117	33	38
39	Other Non-Allowable Cost	-469	43	39
40	Capitalized Repairs & Maintenance	-36701	6	40
41	Copies Income	-15	21	41
42	Election Polling	-100	21	42
43	Community Relations Seminar Cost	-540	24	43
44	Corporate Philanthropy	-5928	20	44
45				45
46				46
47				47
48				48
49	Total	(13,143,376)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Friendship Village-Schaumburg

0023218

Report Period Beginning:

04/01/00

Ending:

03/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(576,999)	0	0	0	0	0	0	0	0	0	0	(576,999)	1
2	Food Purchase	(652,294)	0	0	0	0	0	0	0	0	0	0	(652,294)	2
3	Housekeeping	(624,647)	0	0	0	0	0	0	0	0	0	0	(624,647)	3
4	Laundry	(25,437)	0	0	0	0	0	0	0	0	0	0	(25,437)	4
5	Heat and Other Utilities	(694,603)	0	0	0	0	0	0	0	0	0	0	(694,603)	5
6	Maintenance	(1,094,899)	0	0	0	0	0	0	0	0	0	0	(1,094,899)	6
7	Other (specify):*	(325,159)	0	0	0	0	0	0	0	0	0	0	(325,159)	7
8	TOTAL General Services	(3,994,038)	0	0	0	0	0	0	0	0	0	0	(3,994,038)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(409)	0	0	0	0	0	0	0	0	0	0	(409)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(409)	0	0	0	0	0	0	0	0	0	0	(409)	16
	C. General Administration													
17	Administrative	(346,548)	0	0	0	0	0	0	0	0	0	0	(346,548)	17
18	Directors Fees	(68,133)	0	0	0	0	0	0	0	0	0	0	(68,133)	18
19	Professional Services	(257,506)	0	0	0	0	0	0	0	0	0	0	(257,506)	19
20	Fees, Subscriptions & Promotions	(5,928)	0	0	0	0	0	0	0	0	0	0	(5,928)	20
21	Clerical & General Office Expenses	(905,731)	0	0	0	0	0	0	0	0	0	0	(905,731)	21
22	Employee Benefits & Payroll Taxes	(1,268,092)	0	0	0	0	0	0	0	0	0	0	(1,268,092)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(13,826)	0	0	0	0	0	0	0	0	0	0	(13,826)	24
25	Other Admin. Staff Transportation	(2,257)	0	0	0	0	0	0	0	0	0	0	(2,257)	25
26	Insurance-Prop.Liab.Malpractice	(190,790)	0	0	0	0	0	0	0	0	0	0	(190,790)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,058,811)	0	0	0	0	0	0	0	0	0	0	(3,058,811)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,053,258)	0	0	0	0	0	0	0	0	0	0	(7,053,258)	29

Summary B

Facility Name & ID Number	Friendship Village-Schaumburg	#	0023218	Report Period Beginning:	04/01/00	Ending:	03/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Friendship Village-Schaumburg # 0023218 Report Period Beginning: 04/01/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Friendship Village-Schaumburg # 0023218 Report Period Beginning: 04/01/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Apartment Community
 Street Address 350 W. Schaumburg Road
 City / State / Zip Code Schaumburg, IL 60194
 Phone Number (847) 884-5000
 Fax Number (847) 884-5718

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>Dietary</u>	<u>Meals Ratio</u>	<u>506,548</u>	<u>2</u>	<u>\$ 1,266,927</u>	<u>\$ 1,053,866</u>	<u>275,850</u>	<u>\$ 689,928</u>	1
2	<u>Food Purchase</u>	<u>Meals Ratio</u>	<u>506,548</u>	<u>2</u>	<u>1,430,956</u>	<u>275,850</u>	<u>275,850</u>	<u>779,253</u>	2
3	<u>Housekeeping</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>724,958</u>	<u>648,026</u>	<u>58,526</u>	<u>100,311</u>	3
4	<u>Laundry</u>	<u>Pounds</u>	<u>855,975</u>	<u>2</u>	<u>245,369</u>	<u>174,629</u>	<u>767,236</u>	<u>219,932</u>	4
5	<u>Heat & Utilities</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>806,148</u>	<u>58,526</u>	<u>58,526</u>	<u>111,545</u>	5
6	<u>Maintenance</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>1,228,131</u>	<u>459,909</u>	<u>58,526</u>	<u>169,933</u>	6
7	<u>Other (Disposal, Waste)</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>377,376</u>	<u>58,526</u>	<u>58,526</u>	<u>52,217</u>	7
8	<u>Administrative</u>	<u>Employee Ratio</u>	<u>330</u>	<u>2</u>	<u>638,887</u>	<u>638,887</u>	<u>151</u>	<u>292,339</u>	8
9	<u>Director' Fees</u>	<u>Square Footage</u>	<u>422,795</u>	<u>2</u>	<u>79,080</u>	<u>58,526</u>	<u>58,526</u>	<u>10,947</u>	9
10	<u>Professional Services</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>288,224</u>	<u>58,526</u>	<u>58,526</u>	<u>39,881</u>	10
11	<u>Clerical & General</u>	<u>Employee Ratio</u>	<u>330</u>	<u>2</u>	<u>1,669,572</u>	<u>904,421</u>	<u>151</u>	<u>763,956</u>	11
12	<u>Employee Benefits</u>	<u>Employee Ratio</u>	<u>330</u>	<u>2</u>	<u>2,337,823</u>	<u>151</u>	<u>151</u>	<u>1,069,731</u>	12
13	<u>Insurance</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>211,487</u>	<u>58,526</u>	<u>58,526</u>	<u>29,263</u>	13
14	<u>Depreciation</u>	<u>Actual</u>		<u>1</u>	<u>2,804,987</u>			<u>451,576</u>	14
15	<u>Interest</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>1,202,935</u>	<u>58,526</u>	<u>58,526</u>	<u>166,447</u>	15
16	<u>Real Estate Tax</u>	<u>Square Footage</u>	<u>422,975</u>	<u>2</u>	<u>441,159</u>	<u>58,526</u>	<u>58,526</u>	<u>61,042</u>	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 15,754,019	\$ 3,879,738		\$ 5,008,301	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IL Health Facility						\$ 16,695,000	\$ 10,985,000			\$ 749,772	1	
2	Refinancing Fees										113,179	2	
3	New Issue						30,770,000	30,124,574			339,984	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 47,465,000	\$ 41,109,574			\$ 1,202,935	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 47,465,000	\$ 41,109,574			\$ 1,202,935	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Friendship Village-Schaumburg	COUNTY	Cook
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Index Number	Property Description	Total Tax	

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

527,224

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

590 Independent Apartments - approximate square feet - 418,735

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		Approx. 50 acres	1977	\$ 132,065	1
2					2
3	TOTALS			\$ 132,065	3

Facility Name & ID Number Friendship Village-Schaumburg

0023218

Report Period Beginning:

04/01/00

Ending:

03/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	180		1997	1997	\$ 1,760,825	\$ 44,021	40	\$ 44,021	\$	\$	4
5	10		1993	1993	1,102,771	27,569	40	27,569			5
6	60		1998	1998	2,934,069	73,352	40	73,352			6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1988		42,300	1,692	25	1,692			9
10	Building Improvement		1989		25,957	1,038	25	1,038			10
11	Building Improvement		1992		67,028	6,703	10	6,703			11
12	Building Improvement		1993		12,057	1,206	10	1,206			12
13	Building Improvement		1994		32,598	3,260	10	3,260			13
14	Building Improvement		1995		48,710	4,871	10	4,871			14
15											15
16											16
17	Door alarms for HCC		1996		12,152	1,215	10	1,215			17
18	Workshop - Delivery Area (413,705)		1997		42,735	4,273	10	4,273			18
19	Land Improvement		1997		1,584	106	15	106			19
20	Land Improvement		1986		748	50	15	50			20
21	Land Improvement		1989		830	55	15	55			21
22	Land Improvement		1990		37,561	2,504	15	2,504			22
23	Land Improvement		1992		1,555	104	15	104			23
24	Land Improvement		1993		1,063	71	15	71			24
25	Land Improvement		1994		3,759	251	15	251			25
26	Land Improvement		1995		8,395	560	15	560			26
27	Road Improvement		1987		748		10				27
28	Road Improvement		1988		830		10				28
29	Road Improvement		1989		37,561		10				29
30	Road Improvement		1990		1,555		10				30
31	1995 Building Improvements		1995		215,562	21,297	10	21,297			31
32	1996 Building Improvements		1996		170,156	19,687	10	19,687			32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Outdoor Lighting (104,536)	Oct-97	\$ 107,591	\$ 7,173	15	\$ 7,173	\$	\$		37
38	Exterior Mockup	Oct-97	2,234	223	10	223				38
39	Window Replacement (32,700)	Oct-97	3,378	338	10	338				39
40	HVAC Replacement (81,122)	Oct-97	8,380	838	10	838				40
41	HCC Improvements	Oct-97	470,386	47,038	10	47,038				41
42	Garage/Workshop (74,048)	Oct-98	8,749	219	20	219				42
43	Security Link Equip (31,597)	Oct-98	3,733	373	5	373				43
44	HVAC Renovation (68,768)	Oct-98	8,125	271	15	271				44
45	Health Care Improvement	Oct-98	135,637	4,521	15	4,521				45
46	Windows & Tuckpoint (124,856)	Oct-98	14,752	983	15	983				46
47	Survey Remodel	Oct-98	60,287	2,010	15	2,010				47
48	Generator (2,062,679)	Oct-98	243,703	6,093	20	6,093				48
49	Land Improvements (4,677,072)	Oct-98	552,591	13,815	20	13,815				49
50	Emp Patio Furniture (2,923)	Oct-98	345	69	5	69				50
51	Outdoor Benches (2,514)	Oct-98	297	30	5	30				51
52	Outdoor Lighting (32,536)	Oct-98	3,844	128	15	128				52
53	Landscaping (94,141)	Oct-98	11,123	371	15	371				53
54	Land Improvements (6,007)	Oct-98	710	18	20	18				54
55	Comed Switch (91,148)	Oct-98	10,769	538	10	538				55
56	Computer Cabling (6,556)	Oct-98	775	129	3	129				56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 8,210,518	\$ 299,063		\$ 299,063	\$	\$		70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,210,518	\$ 299,063		\$ 299,063	\$	\$	1
2	Air Conditioner (127,102)	10/01/99	17,591	879	20	879			2
3	Handrails (984)	10/01/99	136	7	20	7			3
4	Window Replacement (125,401)	10/01/99	17,355	868	20	868			4
5	E&F IDPA Renovation	10/01/99	8,750	438	20	438			5
6	SCU Activity Room	10/01/99	134,210	6,711	20	6,711			6
7	Staff Lounge/Confer (164,175)	10/01/99	22,722	1,136	20	1,136			7
8	Expand Emerg Gen Ser (26,407)	10/01/99	3,655	183	20	183			8
9	Dishroom HVAC (167,832)	10/01/99	23,228	1,161	20	1,161			9
10	Automatic Sliding Door (76,034)	10/01/99	10,523	526	20	526			10
11	Kitchen Upgrades (11,946)	10/01/99	1,653	83	20	83			11
12	Landscaping (66,818)	10/01/99	9,248	231	20	231			12
13	Chiller Repair (6690)	5/21/99	926		20	46	46		13
14	Chiller Repair (1230)	6/22/99	170		20	9	9		14
15	Contactore Coil (1697)	9/29/99	235		20	12	12		15
16	Outside Lighting (3237)	1/31/00	448		20	22	22		16
17	Signs (658)	7/7/99	91		20	5	5		17
18	Exhaust Fan (577)	10/4/99	80		20	4	4		18
19	Manifold/Hose/Tubing (795)	5/14/99	110		20	6	6		19
20	R/R Unit (1985)	5/26/99	275		20	14	14		20
21	Ductwork (1800)	6/30/99	249		20	12	12		21
22	Motor (556)	6/14/99	77		20	4	4		22
23	Thermostat Unit (1360)	7/2/99	188		20	9	9		23
24	Temp Control (801)	7/28/99	111		20	6	6		24
25	Gaskets (518)	9/2/99	72		20	4	4		25
26	Motors (5494)	10/25/99	760		20	38	38		26
27	Filter System (1785)	6/22/99	247		20	12	12		27
28	Landscaping (2600)	5/25/99	360		20	18	18		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,463,988	\$ 311,286		\$ 311,507	\$ 221	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,463,988	\$ 311,286		\$ 311,507	\$ 221	\$	1
2	Garage Door Repair (1252)	4/26/99	173		20	9	9		2
3	Entrance Doors (5685)	4/2/99	787		20	39	39		3
4	Tile (3020)	5/10/99	418		20	21	21		4
5	Gutter Hangers (4691)	7/2/99	649		20	32	32		5
6	Overhead Door (2486)	8/31/99	344		20	17	17		6
7	Entry Door (2282)	10/18/99	316		20	16	16		7
8	Garage Door Opener (750)	12/16/99	104		20	5	5		8
9	Carpet (10,965)	4/16/99	1,518		20	76	76		9
10	Bathroom Fixtures (2046)	4/8/99	283		20	14	14		10
11	Bathroom Fixtures (1245)	4/27/99	172		20	9	9		11
12	Tile (1585)	4/8/99	219		20	11	11		12
13	Wall Lighting (1472)	4/16/99	204		20	10	10		13
14	Panels (1585)	4/23/99	219		20	11	11		14
15	Glass (1162)	5/6/99	161		20	8	8		15
16	Cabinets (996)	4/30/99	138		20	7	7		16
17	Garage Doors (1685)	5/5/99	233		20	12	12		17
18	Privacy Handle Set (536)	5/17/99	74		20	4	4		18
19	Air Compressor (909)	5/20/99	126		20	6	6		19
20	Bifold Doors (3247)	5/25/99	449		20	22	22		20
21	Tile (1441)	6/2/99	199		20	10	10		21
22	Bathroom Fixtures (2876)	5/28/99	398		20	20	20		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,471,172	\$ 311,286		\$ 311,866	\$ 580	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,471,172	\$ 311,286		\$ 311,866	\$ 580	\$	1
2	Carpet (4309)	6/11/99	596		20	30	30		2
3	Ceiling Fixture (851)	6/15/99	118		20	6	6		3
4	Manifold Gauge (516)	6/26/99	71		20	4	4		4
5	Asphalt (545)	6/14/99	76		20	4	4		5
6	Paint (1941)	5/19/99	269		20	13	13		6
7	Paint (891)	5/19/99	123		20	6	6		7
8	Base/Studs (900)	5/27/99	125		20	6	6		8
9	Cabinet (656)	6/19/99	91		20	5	5		9
10	Ceiling Fixture (744)	6/22/99	103		20	5	5		10
11	Wraparound Fixture (513)	7/17/99	71		20	4	4		11
12	Circulator Pump	7/21/99	94		20	5	5		12
13	Wall Lamp (557)	7/13/99	77		20	4	4		13
14	Bathroom Fixtures (619)	7/13/99	86		20	4	4		14
15	Paint (1079)	7/9/99	149		20	7	7		15
16	Paint (1954)	7/12/99	270		20	14	14		16
17	Bathroom Fixtures (3126)	7/21/99	433		20	22	22		17
18	Sprinkler Heads (1068)	7/22/99	148		20	7	7		18
19	Thermostat (931)	5/18/99	129		20	6	6		19
20	Thermostat (557)	7/22/99	77		20	4	4		20
21	Tile (613)	7/26/99	85		20	4	4		21
22	Carpet (8695)	8/6/99	1,203		20	60	60		22
23	Tile (1441)	7/21/99	199		20	10	10		23
24	Folding Partitions	8/26/99	742		20	37	37		24
25	Bathroom Fixtures	8/23/99	223		20	11	11		25
26	Wraparound Fixture (596)	9/17/99	82		20	4	4		26
27	Lamp (515)	8/12/99	71		20	4	4		27
28	Wall Lamp (1421)	7/29/99	197		20	10	10		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,477,080	\$ 311,286		\$ 312,162	\$ 876	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,477,080	\$ 311,286		\$ 312,162	\$ 876	\$	1
2	Locks (800)	8/27/99	111		20	6	6		2
3	Ceiling Fixture (818)	8/31/99	113		20	6	6		3
4	Fire Doors (3106)	9/9/99	430		20	21	21		4
5	Paint (2550)	8/24/99	353		20	18	18		5
6	Privacy Handle Set (2144)	9/5/99	297		20	15	15		6
7	Base/Studs (1291)	8/11/99	179		20	9	9		7
8	Flooring (1551)	9/9/99	215		20	11	11		8
9	Carpet (9240)	10/7/99	1,279		20	64	64		9
10	Steel Door Entry (2425)	9/8/99	336		20	17	17		10
11	Bathroom Fixtures (2838)	10/1/99	393		20	20	20		11
12	Thermostat (937)	10/6/99	130		20	6	6		12
13	Lamp (626)	9/24/99	87		20	4	4		13
14	Plumbing (570)	9/29/99	79		20	4	4		14
15	Cabinet (996)	9/6/99	138		20	7	7		15
16	Tile (613)	10/15/99	85		20	4	4		16
17	Flooring (1416)	10/28/99	196		20	10	10		17
18	Paint (3289)	10/26/99	455		20	23	23		18
19	Cabinet (514)	10/22/99	71		20	4	4		19
20	Shower Unit (7807)	11/15/99	1,080		20	54	54		20
21	Carpet (2083)	11/22/99	288		20	14	14		21
22	Col Base (1061)	11/9/99	147		20	7	7		22
23	Cabinet (656)	10/29/99	91		20	5	5		23
24	Thermostat (1992)	10/29/99	276		20	14	14		24
25	Main Contactor (769)	11/10/99	106		20	5	5		25
26	Plumbing (716)	11/24/99	99		20	5	5		26
27	Bathroom Fixtures (2338)	12/04/99	324		20	16	16		27
28	Heater (877)	12/8/99	121		20	6	6		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,484,559	\$ 311,286		\$ 312,537	\$ 1,251	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,484,559	\$ 311,286		\$ 312,537	\$ 1,251	\$	1
2	Carpet (8746)	1/8/00	1,210		20	61	61		2
3	Running Period Timers (1729)	12/27/99	239		20	12	12		3
4	Lamp (1526)	1/4/00	211		20	11	11		4
5	Carpet (3173)	1/24/00	439		20	22	22		5
6	ATS (827)	12/7/99	114		20	6	6		6
7	Flooring (1686)	12/14/99	233		20	12	12		7
8	Paint (1433)	1/7/00	198		20	10	10		8
9	Thermostat (597)	2/1/00	83		20	4	4		9
10	Paint (737)	2/14/00	102		20	5	5		10
11	Filter Panels (1602)	2/21/00	222		20	11	11		11
12	Bathroom Fixtures (733)	2/18/00	101		20	5	5		12
13	Plumbing (706)	3/10/00	97		20	5	5		13
14	Flooring (1334)	3/9/00	185		20	9	9		14
15	Carpet (3935)	3/27/00	545		20	27	27		15
16	Carpet (3844)	3/27/00	532		20	27	27		16
17	Paint (2817)	3/11/00	390		20	19	19		17
18	Pipe (737)	3/6/00	102		20	5	5		18
19	Bathroom Fixtures (1388)	3/10/00	192		20	10	10		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,489,754	\$ 311,286		\$ 312,798	\$ 1,512	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,489,754	\$ 311,286		\$ 312,798	\$ 1,512	\$	1
2	E&F Survey	10/01/00	5,341	534	20	534			2
3	Staff Lounge (22006)	10/01/00	3,054	305	20	305			3
4	Kitchen HVAC (26923)	10/01/00	3,726	373	20	373			4
5	Air Conditioner (142834)	10/01/00	19,768	659	20	659			5
6	Window Replacement (136370)	10/01/00	18,874	629	20	629			6
7	Security Door	10/01/00	15,548	778	20	778			7
8	Garage Door (33116)	10/01/00	4,583	114	20	114			8
9	Redecorating E & F Wing	10/01/00	139,618	9,973	20	9,973			9
10	Front Entrance (229029)	10/01/00	31,698	1,057	20	1,057			10
11	Landscaping (24523)	10/01/00	3,394	113	20	113			11
12	Kitchen Renovation (8695)	10/01/00	1,203	120	20	120			12
13	Elevator Repairs (1302)	09/25/00	180		20	9	9		13
14	Lamp Thermostat (661)	03/06/00	91		20	5	5		14
15	Shower Door (560)	03/20/00	78		20	4	4		15
16	Bifold Doors (2088)	02/23/00	289		20	14	14		16
17	Bifold Doors (988)	03/29/00	137		20	7	7		17
18	Carpet (3760)	04/21/00	520		20	26	26		18
19	Paint (975)	03/31/00	135		20	7	7		19
20	Electrical Work (587)	04/12/00	81		20	4	4		20
21	Shower Unit (4315)	04/06/00	597		20	30	30		21
22	Shower Door (608)	04/06/00	84		20	4	4		22
23	Shower Unit (2048)	04/17/00	283		20	14	14		23
24	Shower Unit (1757)	04/17/00	243		20	12	12		24
25	Cabinet (894)	04/14/00	124		20	6	6		25
26	Drain (911)	05/08/00	126		20	6	6		26
27	ADV Ignitor (523)	04/17/00	72		20	4	4		27
28	Ceiling Fixture (581)	05/12/00	80		20	4	4		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,739,681	\$ 325,941		\$ 327,609	\$ 1,668	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,739,681	\$ 325,941		\$ 327,609	\$ 1,668	\$	1
2	Safety Switch (545)	04/19/00	75		20	4	4		2
3	Refrigerator Repair (1550)	05/04/00	214		20	11	11		3
4	Tile (1441)	05/04/00	199		20	10	10		4
5	ADV Ignitor (522)	05/08/00	72		20	4	4		5
6	Carpet (8283)	05/30/00	1,146		20	57	57		6
7	Paint (999)	05/18/00	138		20	7	7		7
8	Faucets (1025)	04/14/00	142		20	7	7		8
9	Refrigerator Repair (1346)	05/26/00	186		20	9	9		9
10	Refrigerator Repair (1546)	06/16/00	214		20	11	11		10
11	Faucets/Bowls (1510)	06/15/00	209		20	10	10		11
12	Flooring (1294)	06/29/00	179		20	9	9		12
13	Bowl/Tank (536)	06/30/00	74		20	4	4		13
14	Refrigerator Repair (752)	07/26/00	104		20	5	5		14
15	Wallpaper (3713)	02/09/00	514		20	26	26		15
16	Carpet (1258)	08/14/00	174		20	9	9		16
17	Vertical Blinds (541)	09/11/00	75		20	4	4		17
18	Paint (1498)	09/18/00	207		20	10	10		18
19	Faucets (2001)	09/07/00	277		20	14	14		19
20	Bowl/Tank (806)	09/22/00	112		20	6	6		20
21	Paint (1439)	10/28/00	199		20	10	10		21
22	Faucets (544)	10/13/00	75		20	4	4		22
23	Heater (953)	10/24/00	132		20	7	7		23
24	Heater (1094)	12/22/00	151		20	8	8		24
25	Ceiling Heater (970)	12/12/00	134		20	7	7		25
26	Faucet/Bowls (1731)	01/05/01	240		20	12	12		26
27	Faucet/Bowls (1520)	01/18/01	210		20	11	11		27
28	Faucets (554)	03/01/01	76		20	4	4		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,745,209	\$ 325,941		\$ 327,889	\$ 1,948	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,745,209	\$ 325,941		\$ 327,889	\$ 1,948	\$	1
2	Unit Heater (1521)	02/02/01	211		20	11	11		2
3	Thermostat (1451)	02/15/01	201		20	10	10		3
4	Paint (556)	02/05/01	77		20	4	4		4
5	Paint (1480)	02/15/01	205		20	10	10		5
6	Light Fixtures (633)	02/28/01	88		20	4	4		6
7	Downspouts/Gutters (7702)	04/29/00	1,066		20	53	53		7
8	Damper (1084)	01/05/01	150		20	8	8		8
9	Roof Repair (857)	03/30/01	119		20	6	6		9
10	Condenser (2356)	05/27/00	326		20	16	16		10
11	Coil Pans (1128)	06/21/00	156		20	8	8		11
12	Electrical (804)	07/05/00	111		20	6	6		12
13	Actuator Motor (726)	08/10/00	100		20	5	5		13
14	Kit (758)	11/27/00	105		20	5	5		14
15	Heater (988)	02/22/01	137		20	7	7		15
16	Sensor (572)	10/02/00	79		20	4	4		16
17	Irrigation Mainline (955)	11/17/00	132		20	7	7		17
18	Water Heater (23,897)	10/01/00	3,307		20	165	165		18
19	Locksmith (2738)	10/01/00	379		20	63	63		19
20	Signage (1139)	10/01/00	157		20	16	16		20
21	Uninterrupted Power Supply (1613)	10/01/00	223		20	37	37		21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,752,538	\$ 325,941		\$ 328,334	\$ 2,393	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,411,660	\$ 111,426	\$ 111,426	\$		\$	71
72	Current Year Purchases	203,664	10,916	10,916				72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,615,324	\$ 122,342	\$ 122,342	\$		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Business	96 Chevy Pick-up	1996	\$ 8,996	\$ 900	\$ 900	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 8,996	\$ 900	\$ 900	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,508,923	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 449,183	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 451,576	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,393	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$ 54,422		\$ 4,126	\$		\$ 58,548	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,903			6,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	59,061		4,314			63,375	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				645,790		645,790	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): HHA, Clinic, Supplies	39-2		290,660		20,706	4,417		315,783	13
14	TOTAL			\$ 404,143		\$ 36,049	\$ 650,207		\$ 1,090,399	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,347,736	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 74,000)	2,958,039		3
4	Supply Inventory (priced at)	86,841		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	91,191		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	3,049,975		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,533,782	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,565,183		12
13	Land	4,999,257		13
14	Buildings, at Historical Cost	23,363,905		14
15	Leasehold Improvements, at Historical Cost	20,196,126		15
16	Equipment, at Historical Cost	9,042,475		16
17	Accumulated Depreciation (book methods)	(19,696,630)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	18,723,528		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 67,193,844	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 74,727,626	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,589,560	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,100,000		29
30	Accrued Salaries Payable	941,257		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	424,441		32
33	Accrued Interest Payable	628,075		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	893,070		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,576,403	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,009,574		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	36,575,988		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 76,585,562	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 82,161,965	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,434,339)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 74,727,626	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,788,867)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,788,867)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,645,472)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,645,472)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (7,434,339)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Friendship Village-Schaumburg

0023218

Report Period Beginning: 04/01/00

Ending:

03/31/01

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,976,060	1
2	Discounts and Allowances for all Levels	(1,077,539)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,898,521	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	243,421	5
6	Therapy	542,607	6
7	Oxygen	50,016	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 836,044	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	114,413	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	591	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	28,752	16
17	Sale of Drugs	746,471	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,878	19
20	Radiology and X-Ray	3,520	20
21	Other Medical Services	311,939	21
22	Laundry	38,816	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,283,380	23
D. Non-Operating Revenue			
24	Contributions	603,767	24
25	Interest and Other Investment Income***	(79,388)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 524,379	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	11,721,884	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,721,884	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 24,264,208	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	6,079,865	31
32	Health Care	6,235,810	32
33	General Administration	5,534,137	33
B. Capital Expense			
34	Ownership	4,449,081	34
C. Ancillary Expense			
35	Special Cost Centers	3,473,912	35
36	Provider Participation Fee	136,875	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,909,680	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,645,472)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,645,472)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Friendship Village-Schaumburg**# **0023218**Report Period Beginning: **04/01/00**Ending: **03/31/01**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	1,976	\$ 69,583	\$ 35.21	1
2	Assistant Director of Nursing	4,000	3,800	105,624	27.80	2
3	Registered Nurses	72,373	72,202	1,938,056	26.84	3
4	Licensed Practical Nurses	8,476	8,919	136,904	15.35	4
5	Nurse Aides & Orderlies	175,356	184,585	2,461,729	13.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,803	4,003	113,483	28.35	7
8	Rehab/Therapy Aides	5,725	5,439	46,378	8.53	8
9	Activity Director	5,829	6,038	164,404	27.23	9
10	Activity Assistants	13,791	14,715	168,483	11.45	10
11	Social Service Workers	10,278	10,819	138,112	12.77	11
12	Dietician					12
13	Food Service Supervisor	10,666	11,228	295,383	26.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	55,346	58,151	535,354	9.21	15
16	Dishwashers	26,569	27,967	223,129	7.98	16
17	Maintenance Workers	34,511	36,327	459,909	12.66	17
18	Housekeepers	68,611	72,223	648,026	8.97	18
19	Laundry	16,940	17,831	174,629	9.79	19
20	Administrator	1,976	2,080	104,728	50.35	20
21	Assistant Administrator					21
22	Other Administrative	7,904	8,320	634,159	76.22	22
23	Office Manager					23
24	Clerical	44,121	46,495	926,421	19.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	16,347	17,207	188,468	10.95	31
32	Other Health Care(specify)					32
33	Other(specify)	23,011	24,223	312,807	12.91	33
34	TOTAL (lines 1 - 33)	607,713	634,548	\$ 9,845,769 *	\$ 15.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	14,400	9-3	36
37	Medical Records Consultant	Monthly	974	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,215	10-3	39
40	Physical Therapy Consultant	421	17,898	10a-3	40
41	Occupational Therapy Consultant	318	13,570	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	252	10,605	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Utilization Review Fees	Monthly	300	10-3	47
48	Dietary Labor		2,004	1-3	48
49	TOTAL (lines 35 - 48)	991	\$ 75,966		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,781	\$ 281,095	10-3	50
51	Licensed Practical Nurses	835	24,068	10-3	51
52	Nurse Aides	1,837	34,541	10-3	52
53	TOTAL (lines 50 - 52)	9,453	\$ 339,704		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership %		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount				
Robert Alston	CEO	0	\$ 222,495	Workers' Compensation Insurance	\$ 210,261	IDPH License Fee	\$				
Michael Flynn	CFO	0	150,571	Unemployment Compensation Insurance	12,904	Advertising: Employee Recruitment	66,443				
Joseph Xanthopoulos	VP Planning & Adv	0	121,527	FICA Taxes	735,187	Health Care Worker Background Check (Indicate # of checks performed <u>20</u>)	700				
Stephen Yenchek	VP Ops. & Corp. Dev.	0	139,566	Employee Health Insurance	1,071,879	Alliance Membership	32,496				
Helene Corcoran	Administrator	0	104,728	Employee Meals		Association Dues	31,094				
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions/Publications	28,546				
				Employee Activities/Assistance	35,724						
				Employee Programs	21,289						
				Life/Disability Insurance/Vaccinations	61,884						
				Recruitment Physicals	15,282						
				Retirement/401K	171,677						
				Less: Allocated to Non-HCC	(1,268,092)						

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Friendship Village-Schaumburg

STATE OF ILLINOIS

0023218

Report Period Beginning:

04/01/00

Ending:

Page 23

03/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. AHSA \$7400; LSN \$16,768
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 127,516 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 136,875
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (See page 8) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 591
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.